Anthem KeyCare 20 Plan

In-Network Services	You Pay
Preventive Care Services	
o well-baby visits o immunizations o checkups o gynecological exams o prostate exams	$20 for each visit to a family or general practitioner, internist or pediatrician $35 for each visit to a specialist
o Pap tests o mammograms o Prostate Specific Antigen (PSA) tests o screening tests	20% of the amount the health care professionals in our network have agreed to accept for their services
Doctor Visits	
o office visits o pre- and postnatal office visits* o in-office surgery o urgent care visits o mental health and substance abuse visits o speech therapy visits in an office setting (30 visit limit)** o physical and occupational therapy in an office setting (30 combined visits)** o spinal manipulations and other manual medical intervention visits (30 visit limit)** **If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)* ***Limit does not apply to Early Intervention and Autism Spectrum Disorder.*	$20 for each visit to a family or general practitioner, internist or pediatrician $35 for each visit to a specialist
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * *Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o limited to a $35,000 per member annual maximum	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
**Unlimited physical, occupational and speech therapy*	Member cost shares will be dependent on the services rendered.
Labs, X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o dialysis o chemotherapy (not given orally) o radiation therapy o respiratory therapy o infusion services o shots and therapeutic injections, including infusion medications	20% of the amount the health care professionals in our network have agreed to accept for their services
o durable medical equipment o professional ground ambulance services o medical appliances, supplies and medications o private duty nursing (16 hours per member per year)* **Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.*	20% of the amount the health care professionals in our network have agreed to accept for their services
Prescription Drug Plan (10-30-45)	
o up to a 30-day medication supply at participating retail pharmacies o up to a 90-day medication supply delivered to your home using the Mail Order Pharmacy	Retail Pharmacy: $10/30/45 (30-day supply) Mail Order Pharmacy: $20/60/90 (90-day supply)
Outpatient Visits in a Hospital or Facility	

o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* **Limit does not apply to Early Intervention and Autism Spectrum Disorder.*	$35 plus 20% of the amount the health care professionals in our network have agreed to accept for their services
o emergency room o surgery **For the services billed by the doctor, you will pay an additional $20 or $35 depending on the type of doctor who treats you.*	$100 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

In-Network Services	You Pay
Care at Home	
o hospice care o home health care visits by a nurse or aide (90 visits)	No charge
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit **You do not have to pay another $300 if you are readmitted within 90 days of the day you went home.*	$300 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay $2,300 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $2,300 ($4,600 total).
- If three or more people are covered under your plan, together you will pay $4,600. However, no family member will pay more than $2,300 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $4,600 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $4,600 ($9,200 total).
- If three or more people are covered under your plan, together you will pay $9,200. However, no family member will pay more than $4,600 toward the limit.

*The following do not count toward the calendar year out-of-pocket maximum:

- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 20 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay
- the cost of prescription drug co-pays